PHANTOM MEDICAL, INC

Neal H. Patel, D.O.

1240 E. Chapman Ave, Orange, CA 92866

Tel: 714-771-2800 | Fax: 714-771-3200

www.PhantomMed.com

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

GENERAL

Name (Last, First, Middle):_____

Date of Birth (MM/DD/YYYY):_____ Social Security #:_____

Gender:_____ Driver's License #:_____ State:_____

Marital Status: [] Single [] Married [] Divorced [] Separated [] Partner [] Other:_____

CONTACT INFORMATION

Home Address: Street_____City_____State_____Zip_____

Home Phone #:_____Fax #:_____ Cell Phone #:_____

Employer Name:_____ Occupation:_____

Work Address: Street_____City_____State_____Zip_____

Work Phone #:_____ Email Address:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

PRIMARY INSURANCE

Name of Primary Insurance Co:_____ Phone #:_____

ID / Policy #:_____ Group #:_____

Subscriber / Insured:_____ Relationship:_____ Gender:_____

Date of Birth (MM/DD/YYYY):_____ Social Security #:_____

Employer Name:_____ Employer Phone #:_____

SECONDARY INSURANCE

Name of Secondary Insurance Co:_____ Phone #:_____

ID / Policy #:_____ Group #:_____

Subscriber / Insured:_____ Relationship:_____ Gender:_____

Date of Birth (MM/DD/YYYY):_____ Social Security #:_____

Employer Name:_____ Employer Phone #:_____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, assign directly to Phantom Medical, Inc., all surgical and / or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not. I hereby authorize the Doctor to release all information necessary to secure payment of benefits.

Signature:_____ Date:_____

(If patient is a minor, Signature of parent or Guardian authorizing treatment)

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IMPORTANT INFORMATION ABOUT YOUR PHYSICAL/MEDICAL EXAM

Dear Patient: (Established and New Patients)

Please note that your physical exam consists to two parts:

This pertains to your MEDICAL exam and is billed under the 99205 (new patients) or 99215 (established patients) code.

This part consists of detailed history taking to address all your medical problems, medications, and a detailed review of all systems to diagnose and formulate an appropriate treatment plan. This often requires ordering appropriate blood tests and diagnostic procedures to determine how to treat you accordingly. This code and the tests ordered are often subjected to your MEDICAL DEDUCTIBLE which will be your responsibility along with checking with your insurance plan.

The second part consists of your Preventive exam which is often performed on a separate visit. This part is billed with either a 99395, 99396, or 99397 code depending on your age bracket for established patients or 99385, 99386, or 99387 for new patients depending on your age bracket. The diagnosis code used for this exam is V70.0 which stands for the preventive exam. This part purely addresses all the appropriate preventive measures and addresses your vaccine needs, preventative health screenings, evaluations of your social and mental health, fall prevention, dietary counseling, etc.

Please note that this part DOES NOT address the diagnosis and treatment of your ongoing medical conditions or any new medical complaints or problems. This is generally covered by most insurance plans once a year and is also covered by MEDICARE once every 13 months (again, please check your insurance plan about your coverage).

I hope you do understand that we, as Board certified physicians, aim to address & meet ALL of your medical needs for your continued physical, mental, emotional, and spiritual well being in the years to come.

Patient or Patient's Legal Guardian (PRINT)	Signature	Date

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ADVANCE BENEFICARY NOTICE (ABN)

Name:_____ **DOB:**_____ **ID:**_____

Medicare/PPO may not pay for the item(s) or service(s) that are described below. Medicare/PPO may not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare/PPO rules are met. The fact that Medicare/PPO may not pay for a particular item or service does not mean that you should not receive it, and there may be a good reason your doctor recommended it.

Items or Services:

Annual Physical Exam:	99215 = $200.00
Preventive Medical Exam:	99395 or 99396 or 99397 = $150.00

The purpose of this form is to help you make an informed decision about whether you want to receive these items or services, knowing that you may have to pay for them yourself. Before you decide, you should read this entire notice carefully.

- Ask us to explain if you do not understand why Medicare might not pay.
- Ask us how much these items or services will cost you (Estimated cost: $150 / $200) in case you do have to pay for them yourself or through another insurance.

Please choose from one of the options below.

☑ **Option 1: Yes. I want to receive these items or services.**

I understand that Medicare/PPO will not decide whether to pay unless I receive these items or services first. Please submit my claim to Medicare/PPO. I understand that you may bill me for the items or services first, and that I may have to pay the bill while Medicare/PPO is making their decision. If Medicare/PPO does pay, I will be refunded to me any payments I made to you that are due to me. If Medicare/PPO denies payment, I agree to be personally and fully responsible for the entire payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I have the right to appeal Medicare/PPO's decision.

☐ **Option 2. No. I choose NOT to receive these items or services.**

I will not receive these items or services, and I understand that you will not be able to submit a claim to Medicare/PPO. I understand I will not be able to appeal your opinion that Medicare/PPO will not pay.

_____ _____ _____

Patient or Patient's Legal Guardian (PRINT) Signature Date

Note: Your health information and any information that we collect on this form will be kept confidential in our office. If a claim is submitted to Medicare/PPO, your health information may be shared with them but will be kept confidentially by Medicare/PPO as well.

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COVID – 19 (CORONAVIRUS) TIPS

Per the World Health Organization (WHO), "COVID-19 is the disease caused by a new coronavirus called SARS-CoV-2. WHO first learned of this new virus on December 31st, 2019, following a report of a cluster of cases of 'viral pneumonia' in Wuhan, People's Republic of China." Since its discovery, it has spread throughout the world and is now considered a pandemic. Given this new virus and continuously emerging information, it is important to stay and aware and up to date of the current situation. Please consider the following tips and information to help you stay safe during this unprecedented time.

- Common symptoms include: fever, dry cough, shortness of breath, fatigue, loss of smell/taste, chills, or muscle aches, congestion, runny nose, etc
- RED flag symptoms include: blue lips/face, coughing up blood, confusion, non-blanching rash, severe chest pain, severe shortness of breath, or elevated heart rate.
- Symptoms typically appear within 5 days of exposure.
- **Please make sure to:**
    - Follow the recommendations put in place per the Centers for Disease Control and Prevention (CDC).
    - Stay home as much as possible.
    - Avoid crowds.
    - Maintain at least 6 feet of separation from others whenever possible, including within the household.
    - Wear a face mask that covers BOTH your nose and mouth, including when at home.
    - Wash your hands often with soap and water for at least 20 seconds OR rub hand sanitizer that contains at least 60% alcohol on your hands for at least 20 seconds.
    - Cover your cough or sneeze with a tissue, and then throw that tissue away in the trash.
    - Avoid touching your eyes, nose, or mouth.
    - Avoid contact with people who are sick.
    - Continue to rest, drink plenty of fluids, and watch for signs and symptoms of worsening infection.
    - Consider buying a pulse oximeter and thermometer to monitor your oxygen status and temperature, respectively.
- **Testing, Vaccination, and Treatment:**
    - Home Testing – rapid way to determine if exposed
    - PCR test – confirmatory test; a positive result is good at ruling IN a recent infection
    - Getting vaccinated with either Moderna, Johnson and Johnson, or Pfizer vaccines is recommended along with getting the booster if not already done so.
    - If exposed to COVID, please call immediately and determine if you are a candidate for Paxlovid treatment.

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FALL PREVENTION TIPS

Falls are the leading cause of injury and accidental death in adults over the age of 65. New or unfamiliar surroundings, improper footwear, cumbersome furniture arrangements, and distractions can all cause a person to accidentally stumble or fall. According to the World Health Organization, 28-35% of people over the age of 65 will fall each year. Grace L. Walker, PT, DPT, OTD, says: "If a patient is unable to stand on one leg for one minute without support, this may be a good candidate for our balance and fall prevention program." Please consider the following recommendations to lower your risk of falls.

- Be sure to have adequate lighting throughout the house (hallways, bathrooms, doorways, etc).
- Wear appropriate footwear. When walking long distances or in unfamiliar areas, wear flat, non-slip shoes that fit snug and are comfortable. Avoid high heels, loose-fitting shoes, or slip-on backless shoes.
- Install railings in hallways and grab bars in the bathrooms and showers to prevent slipping.
- Install nonslip strips or a rubber mat on the floor of the tub or shower, and consider using a shower seat.
- Arrange furniture so that it creates plenty of room to walk freely. If you are using a walking aid, ensure that doorways and hallways are large enough to get through with and without any devices you may use. Clear all hallways and doorways of items and clutter.
- Do not walk and talk at the same time. Concentrate on the task of walking and continue the conversation after you have reached a safe place.
- Remove throw rugs or secure them firmly to the floor.
- Know your limitations. If there is a task you cannot complete with these considerations, then do not risk a fall by trying to complete it.
- When getting up from bed, take a few minutes to orient yourself before getting out of bed.
- Use caution when carrying items while walking.
- Stay active and perform regular strengthening and balancing exercises.

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FALL PREVENTION, BALANCE, AND DIZZINESS SURVEY

Name:_____

DOB:_____ **Date:**_____ **Age:**_____

To help determine if you are at significant risk for a fall or have a balance disorder, please take the survey below. If you answer yes to one or more of these questions, you could be at risk. The best way to determine if you have a problem is to share with your doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he/she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer	**Yes or Often**	**Sometimes**	**No or Never**
Have you had a recent loss of or decrease in your vision or hearing?			
Have you fallen 2 or more times in the past year, fallen and had an injury, or fallen without an obvious reason?			
Do you fear falling?			
Does moving your head quickly make you dizzy or cause to you feel nauseous?			
Does dizziness or imbalance interfere with your job or your household responsibilities?			
Do you use a walker, cane, or any other form of assistance for your mobility?			
Are you ever dizzy or unsteady when you first get up in the morning?			
Do you ever fall or feel like you are about to fall for no apparent reason?			
Does walking down the aisle of a super market or stopping next to moving traffic make you dizzy?			
Do you feel dizzy while sitting down or rising from a seated or lying position?			
Do you feel unsteady when you are walking or climbing stairs?			
Do you ever lose your balance or feel dizzy or unsteady?			
Has your balance concerns caused problems in your social life?			
Have you continued to experience dizziness after an injury or accident?			
Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			

Patient Signature:_____ Phone:_____

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GENERALIZED ANXIETY DISORDER (GAD-7) SCREENING

Name:_____

DOB:_____ **Date:**_____ **Sex: Male** ☐ **Female** ☐

1. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days (1)**	**More than half the days (2)**	**Nearly everyday (3)**
Feeling nervous, anxious, or on edge?				
Not being able to stop or control worrying?				
Worrying too much about different things?				
Trouble relaxing?				
Being so restless that it is hard to sit still?				
Becoming easily annoyed or irritable?				
Feeling afraid as if something awful might happen?				
TOTAL 0				

2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Total Score	**Anxiety Severity**
0 – 4	Minimal
5 – 9	Mild
10 – 14	Moderate
15 – 21	Severe

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INSURANCE WAIVER

I understand that it is my responsibility to supply Dr. Patel's office with any current insurance information. I also understand that at the time of my appointment, if my insurance cannot be verified or determined that I am not eligible for coverage, I will be responsible for the payment for all services provided.

_____ _____ _____

Patient or Patient's Legal Guardian (PRINT) Signature Date

MEDICARE PATIENTS ONLY

This letter is to inform you that Medicare will or may not cover routine exams. You will be financially responsible for the cost.

_____ _____ _____

Patient or Patient's Legal Guardian (PRINT) Signature Date

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MAINTAINING A HEALTHY LIFESTYLE

Our focus for your health is to prevent disease. Please read the following advice to help you stay in the best possible physical, mental, emotional, and spiritual health.

1. Eat healthy foods. Increase fiber, hydration, and eat plenty of fruits and vegetables.
2. Exercise regularly. It is recommended to do at least 150 minutes of aerobic exercise per week (swimming, running, walking, cycling) and at least 2 days per week of muscle strengthening activities (squats, weights, yoga, resistance bands).
3. Always wear a seatbelt when in a car and always wear a helmet when riding a bicycle.
4. Use sunscreen when exposed to the sun with SPF 30 or higher and both UVA/UVB.
5. Consider intermittent fasting (16 hours per day) or prolonged fasting (24-72 hours) to help with losing weight and helping with many different medical ailments.
6. Immunize yourself with the Influenza (Flu) vaccine every year in the Fall and Tetanus Toxoid vaccine every 10 years. Obtain the Shingrix vaccine if you are 50 years or older.
7. Practice safe sex using condoms and get tested for sexually transmitted diseases (STDs) if concerned or with a new partner.
8. Consider a daily dose of Vitamin E (180 mg or 400 International Units) to help with memory and as an antioxidant.
9. To prevent osteoporosis and help overall bone health, consider daily calcium (1000 mg - 1200 mg) and daily Vitamin D3 (2000 – 4000 International Units).
10. Cigarette smoking and alcohol has been linked to many health diseases and it is important to quit or if concerned about your use. We encourage you to talk to Dr. Patel about ways to quit.
11. Avoid and try to quit illicit street drugs.
12. Practice mindful techniques (yoga, meditation, music, art, journaling, humor, deep breathing).
13. Be involved in your community and have a strong support system.

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify*)		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

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PATIENT HEALTH QUESTIONAIRRE (PHQ-9) SCREENING

Name:_____

DOB:_____ **Date:**_____ **Sex: Male** ☐ **Female** ☐

1. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days (1)**	**More than half the days (2)**	**Nearly everyday (3)**
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself - or that you are a failure, or have let yourself or your family down?				
Trouble concentrating on activities, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or off hurting yourself in some way?				
TOTAL 0				

2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Total Score	**Depression Severity**
0 – 4	None
5 – 9	Mild
10 – 14	Moderate
15 – 19	Moderate severe
20 – 27	Severe

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PERIPHERAL VASCULAR DISEASE (PVD) QUESTIONNAIRE

Name:_____

DOB:_____ **Date:**_____ **Age:**_____ **Sex:** **Male** ☐ **Female** ✔

Answers to the following questions will help determine if you are at risk for PVD and if a vascular examination can help better assess your vascular health status.

Do you experience any pain in your legs or feet while at rest?	☐ Yes	☑ No
Have you ever had any testing done for your legs for poor circulation?	☑ Yes	☐ No
Have you ever been told you have diabetes?	☐ Yes	☐ No
Do you have high blood pressure or are you on blood pressure medication?	☐ Yes	☐ No
Do you have high cholesterol or on a medication to lower your cholesterol?	☐ Yes	☐ No
Do you smoke or have you ever smoked?	☐ Yes	☐ No
Have you ever been told that you have had a heart attack or stroke?	☐ Yes	☐ No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication, or peripheral arterial disease?	☐ Yes	☐ No
Have you ever had an angioplasty or stent placed in your heart or leg?	☐ Yes	☐ No
Do you have a history of carotid stenosis or aneurysm?	☐ Yes	☐ No
Do you have any infections or sores that are not healing on your legs, feet, or toes?	☐ Yes	☐ No
Has your walking pace slowed enough to significantly alter your daily activities?	☐ Yes	☐ No
Do your legs ever feel tired or heavy causing you to stop and rest? Do they get better with rest?	☐ Yes	☐ No
When you walk, do you ever have to stop because you have pain or cramping in your calves, thighs, or buttocks? Does the pain go away with rest?	☐ Yes	☐ No
Do you ever experience cramping, tightness, “Charlie horses,” or pain in the legs or feet when lying down that improves when you stand up?	☐ Yes	☐ No
Have you given up activities you once enjoyed doing over the last year due to leg fatigue, weakness, or discomfort?	☐ Yes	☐ No
Have you ever had trauma to either of your legs?	☐ Yes	☐ No

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PREPARING FOR YOUR DOCTOR'S VISIT

Name:_____ DOB:_____ Date:_____

Fill out the information below to the best of your ability. Please share it with your doctor. Be open and honest in answering any questions your doctor may ask you about the changes you have been experiencing.

Has your health, memory, or mood changed?

_____

_____

How has it changed?

_____

_____

When did you first notice this change?

_____

_____

How often does it happen?

_____

_____

When does it happen? Is it during a certain time of the day?

_____

_____

What do you do when it happens?

_____

_____

Do you have problems with any of the following?

Repeating or asking the same thing over and over again?

Never ◯ Sometimes ◯ Frequently ◯ Does not apply ◯

Remembering appointments, family occasions, holidays, or birthdays?

Never ◯ Sometimes ◯ Frequently ◯ Does not apply ◯

Name:_____ **DOB:**_____ **Date:**_____

Writing checks or paying bills?

Never ◯ Sometimes ◯ Frequently ◯ Does not apply ◯

Shopping independently (ie. clothing, groceries)

Never ◯ Sometimes ◯ Frequently ◯ Does not apply ◯

Taking medications according to the instructions?

Never ◯ Sometimes ◯ Frequently ◯ Does not apply ◯

Getting lost while walking or driving to familiar places?

Never ◯ Sometimes ◯ Frequently ◯ Does not apply ◯

<u>Medications and Medical History</u>

List your prescription medications (dosage, frequency) including over the counter medications.

_____

_____

List vitamins and herbal supplements.

_____

_____

List your current medical conditions.

_____

_____

List your past medical conditions.

_____

_____

<u>Questions to ask the doctor:</u>

- What tests do I need to take and how long will it take to get the results?
- Will you refer me to a specialist if needed?
- Could the medicines I am taking be causing my symptoms?
- Do I have any other conditions that could be causing my symptoms or making them worse?
- What should I expect if it I am diagnosed with Alzheimer's Disease?
- What treatments are available for Alzheimer's Disease? What are the risks, benefits, and side effects?
- What about participating in a clinical trial? What are the risks and benefits?
- Is there anything else I should know regarding my health?
- When should I come back for another visit?

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SLEEP QUESTIONNAIRE (EPWORTH SCALE)

Name:_____ **DOB:**_____ **Age:**_____

Date:_____ **Height:**_____ **Weight:**_____ **Sex: Male** ☐ **Female** ☐

How likely are you to nod off or fall asleep in the following situations, compared to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number for each situation.

	0 = Would **never** nod off	1 = **Slight** chance of nodding off	2 = **Moderate** chance of nodding off	3 = **High** chance of nodding off
Sitting and reading	0 ◯	1 ◯	2 ◯	3 ◯
Watching TV	0 ◯	1 ◯	2 ◯	3 ◯
Sitting, inactive, in a public place (meetings, theater, or dinner event)	0 ◯	1 ◯	2 ◯	3 ◯
As a passenger in a car for an hour or more without a break	0 ◯	1 ◯	2 ◯	3 ◯
Lying down to rest when circumstances permit	0 ◯	1 ◯	2 ◯	3 ◯
Sitting quietly and talking to someone	0 ◯	1 ◯	2 ◯	3 ◯
Sitting quietly after lunch without alcohol	0 ◯	1 ◯	2 ◯	3 ◯
In a car, while stopped for a few minutes in traffic	0 ◯	1 ◯	2 ◯	3 ◯

Total Score: 0_____

A score of 10 or greater raises concerns that: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

Sleep Questionnaire:

Do you snore?	☐ Yes ☐ No	Do you wake up tired?	☐ Yes ☐ No
Do you have trouble falling asleep?	☐ Yes ☐ No	Do you wake up choking/gasping for air?	☐ Yes ☐ No
Do you have high blood pressure?	☐ Yes ☐ No	Are you depressed?	☐ Yes ☐ No
Do you wake up with a headache?	☐ Yes ☐ No	Do you have night sweats?	☐ Yes ☐ No
Are you tired throughout the day?	☐ Yes ☐ No	Do you have shortness of breath?	☐ Yes ☐ No